

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/15/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/14/2011
NAME OF PROVIDER OR SUPPLIER UNICOI CO NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 GREENWAY CIRCLE ERWIN, TN 37650	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure the resident's right to make choices on when to use a personal telephone for one resident (#4) of fifteen residents reviewed. The findings included: Resident #4 was admitted to the facility on October 25, 2005, and re-admitted on January 25, 2011, with diagnoses including Ischemic Bowel Disease, Diabetes Mellitus, and Parkinson Disease. Medical record review of the Minimum Data Set (MDS) dated February 4, 2011, revealed the resident scored twelve out of fifteen (fifteen being the highest cognitive status) on the Brief Interview for Mental Status (cognitive status). Continued review of Section G of the MDS revealed, "...Res interview: use phone in private: (1) Very important..." Medical record review of a nurse's note dated March 26, 2011, at 2110 (9:10 p.m.), revealed,	F 242	All staff members will be in-serviced on resident rights by social worker. (Resident #4) Phone was turned back on. (Resident #4) In-service posted for all staff members to read and sign by social worker. That Resident #4's phone was plugged in on 4/12/11 and the phone is not to be unplugged in the future unless she requests it. Other Resident's phones are not to be unplugged unless requested by the Resident. Social Worker will educate all new staff members on Resident rights during new employee orientation.	5/2/11 4/12/11 4/12/11 Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 242	Continued From page 1 "...resident became very upset when (resident's) phone was unplugged as requested by family...wanted to speak with family...Refused to accept that it had been being unplugged at 2100 (9:00 p.m.), each night..." Observation and interview in the resident's room on April 12, 2011, at 1:00 p.m., revealed a cordless phone on the overbed table and the resident stated, "I do not want my phone unplugged; you never know when somebody may need me and if my phone is unplugged, they can't reach me." Interview in the MDS Coordinator's office with the Social Services Director and Director of Nursing on April 12, 2011, at 3:15 p.m., confirmed the facility unplugged the resident's phone each night. Continued interview confirmed the facility failed to ensure the resident's choice to keep the phone plugged up at night.	F 242	Social worker will randomly review one chart weekly to ensure Residents right to make choices are being met. NHA or DON must approve any instances when the Resident's choices concerning significant aspects of his or her life are in conflict with family wishes so that any questions can be resolved immediately.
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